CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

August 31, 2000

Amendment 3598 to H.R. 4577
The Medicare Outpatient Drug Act of 2000

As printed in the Congressional Record of June 22, 2000

SUMMARY

The Medicare Outpatient Drug Act of 2000 would establish a voluntary outpatient prescription drug benefit, beginning in 2003, under a new Part D of Medicare.

The Congressional Budget Office (CBO) estimates that this proposal, if enacted, would have no budgetary impact in 2000 or 2001. However, it would increase direct spending by $61 billion over the 2002-2005 period and $246 billion over the 2002-2010 period. The proposal would also reduce revenues by about $1 billion through 2010. Assuming that the necessary amounts are appropriated, CBO estimates that discretionary spending would total $5 billion through 2010. Because the proposal would affect direct spending and revenues, pay-as-you-go procedures would apply.

The bill contains no private-sector or intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). State spending for Medicaid would increase by about $1 billion over the 2001-2005 period, but state, local, and tribal governments could also realize savings in their employee retirement programs because of incentive payments provided by the proposal.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the Medicare Outpatient Drug Act is shown in Table 1. The proposal would affect mandatory spending in budget functions 550 (health) and 570 (Medicare) and would add to discretionary spending by all agencies. It also would reduce federal revenues.

TABLE 1. ESTIMATE OF THE BUDGETARY EFFECT OF THE MEDICARE OUTPATIENT DRUG ACT OF 2000 (Outlays, by fiscal year, in billions of dollars)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total, 2001-2005	Total, 2001-2010
Direct Spending												
Medicare												
Benefits	0	0	25.5	37.7	42.6	47.7	53.2	59.6	66.7	74.7	105.9	407.7
Part D premium receipts	0	0	-13.0	-19.2	-21.6	-24.2	-27.0	-30.2	-33.7	-37.8	-53.8	-206.6
Subsidy to health plans for retirees	0	0	0.6	0.9	1.0	1.1	1.3	1.4	1.6	1.8	2.5	9.7
Subtotal	0	0	13.2	19.5	22.0	24.6	27.5	30.8	34.5	38.7	54.6	210.8
Medicaid (federal share)[a]												
Part D benefits and premiums	0	0	2.5	4.6	6.3	7.4	8.3	9.3	10.4	11.7	13.4	60.5
Change to current-law drug spending	0	0	-2.8	-4.1	-4.7	-5.3	-6.0	-6.8	-7.6	-8.6	-11.6	-46.0
Part A/B benefits and premiums	0	0	0.4	1.1	1.9	2.3	2.4	2.6	2.8	3.1	3.5	16.8
Administrative costs	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.6	1.4
Effect of higher drug prices on Medicaid	0	0	*	0.1	0.1	0.2	0.2	0.4	0.5	0.7	0.2	2.2
Subtotal	0	0.1	0.4	1.8	3.8	4.6	5.1	5.7	6.3	7.0	6.1	34.9
Effect of higher drug prices on FEHB program (for annuitants)	0	0	*	*	*	*	*	*	*	0.1	*	0.2
Total	0	0.1	13.6	21.2	25.8	29.3	32.7	36.5	40.8	45.8	60.7	245.8
Revenues												
Income and Medicare Payroll Taxes (on-budget)	0	0	*	*	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.1	-0.9
Social Security Payroll Taxes (off-budget)	0	0	*	*	*	*	-0.1	-0.1	-0.1	-0.1	*	-0.4
Total	0	0	*	*	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-0.1	-1.3
Spending Subject to Appropriations												
Administration of drug benefit	0	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.6	1.6	4.2
Effect of higher drug prices on FEHB program (for active workers) and other federal purchasers	0	0	*	*	*	*	0.1	0.1	0.1	0.1	0.1	0.5
Total	0	0.3	0.4	0.4	0.5	0.5	0.6	0.6	0.6	0.7	1.6	4.7

NOTES: * = costs or savings less than $50 million; FEHB program = Federal Employees Health Benefits Program.

BASIS OF ESTIMATE

The proposal would create a voluntary outpatient prescription drug benefit, beginning in 2003, under a new Part D of Medicare. That benefit would be operated by states or private entities that are awarded a contract to serve a geographic area by the Secretary of Health and Human Services. The Secretary would award at least two contracts in each area (if at least two entities submit qualified bids) and would arrange to provide the drug benefit in areas not covered by a contract.

In 2003 and 2004, a $250 annual deductible would apply, although the contracting entity could waive that deductible for generic drugs. The beneficiary would then be responsible for paying 50 percent coinsurance on the next $6,500 of total drug spending and 25 percent coinsurance on subsequent spending until the beneficiary reaches a $4,000 limit on out-of-pocket spending (see Table 2). That limit would be reached when total drug spending reaches $8,750, and the plan would cover all subsequent spending in that year. Beginning in 2005, the deductible and cost-sharing amounts would be updated annually by the percentage increase in average per-capita expenditures for covered outpatient drugs for Medicare beneficiaries.[1] The insured component of the benefit would be financed equally by premium payments withheld from enrollees' Social Security checks and by general tax revenues.

TABLE 2. SCHEDULE OF BENEFICIARY'S OUT-OF-POCKET SPENDING FOR PRESCRIPTION DRUGS IN 2003 AND 2004

Total Annual Spending	Percentage Paid by Beneficiary	Annual Out-of-Pocket Spending by the Beneficiary[a]	
		Spending in the Interval	Cumulative Spending
$0 to $250	100 percent	$ 250	$ 250
$250.01 to $6,750	50 percent	3,250	3,500
$2,350.01 to $8,750	25 percent	500	4,000
Above $8,750	0 percent	0	4,000

a. Assumes beneficiary spends the full amount in the interval.

1. The amendment printed in the Congressional Record on June 22, 2000, contains a drafting error that would result in the deductible and cost-sharing amounts being updated by the percentage increase in total expenditures for covered outpatient drugs for Medicare beneficiaries, rather than by the percentage increase in average per-capita expenditures. The estimate assumes updates would be based on average per-capita expenditures.

The premiums and cost-sharing payments of certain low-income Medicare beneficiaries would be subsidized through the Medicaid program. Subsidies would be available to beneficiaries who are fully eligible for both Medicare and Medicaid or have income below 150 percent of the poverty level. (People with income between 135 percent and 150 percent of the poverty level would only receive assistance with their premiums, on a sliding-scale basis.) The federal government would pay for subsidies for people who are fully eligible for both programs and for other beneficiaries with income below 120 percent of the poverty level at the normal Medicaid matching rate (57 percent, on average), with states paying the rest. Subsidy costs for other beneficiaries would be paid entirely by the federal government.

The proposal also includes an incentive that is intended to preserve employer-sponsored drug coverage for retirees. Medicare would pay employers 67 percent of the premium-subsidy costs it would have incurred if their retirees had enrolled in Part D instead. In addition, enrollees in Medicare's managed care plans would receive their prescription drug coverage through those plans, which for the first time would be paid directly for providing such coverage (for enrollees who opt for the Part D benefit).

CBO's cost estimate assumes that everyone who participates in Part B of Medicare would also participate in Part D, with one exception: a quarter of those beneficiaries who have drug coverage through health plans for retirees would retain that coverage. In addition, CBO assumes that people who are eligible for benefits under Part B but do not enroll would also not enroll in Part D. Under those assumptions, nearly 36 million people would sign up for Part D in 2003, 2.5 million would receive prescription drug coverage from employer-sponsored plans, and 2.5 million Medicare enrollees would have no federally-subsidized prescription drug coverage.

Medicare and Medicaid Spending for the Prescription Drug Benefit

CBO estimates that the proposed prescription drug benefit would increase direct spending by $61 billion over the 2001-2005 period and $246 billion over the 2001-2010 period.

Medicare Spending. The bulk of estimated spending for the prescription drug benefit over 10 years ($211 billion) would come from Medicare. Payments for drug benefits would total an estimated $408 billion through 2010, but they would be partially offset by $207 billion in premiums paid by beneficiaries. (CBO estimates that the premium for Part D would start at about $40 a month in 2003 and rise to about $80 in 2010.) In addition, subsidies for employer-sponsored drug coverage would total $10 billion over the 2001-2010 period.

Medicaid Spending. The prescription drug proposal would also increase net federal spending for Medicaid—by $6 billion through 2005 and $35 billion through 2010, CBO

estimates. The premium and cost-sharing subsidies that Medicaid would pay for low-income Medicare beneficiaries would cost the federal government $60 billion over 10 years, but that increase would be partly offset by savings in Medicaid, because Medicare would replace Medicaid as the primary payer for drug spending for people who were fully eligible for both programs. CBO estimates that the federal share of those Medicaid savings would total $46 billion through 2010. In addition, Medicaid spending would rise by $17 billion over 10 years because the new drug benefit would induce more low-income Medicare beneficiaries to enroll in Medicaid. Finally, Medicaid's administrative spending would rise by $1 billion through 2010 because of the costs of administering subsidies and handling claims for new Medicaid enrollees.

Administrative Costs. In addition to direct spending for Medicare and Medicaid, the proposed drug benefit would necessitate additional administrative costs to hire additional staff, promulgate regulations, contract with pharmacy benefit managers, buy computer systems, notify beneficiaries, and prepare the Social Security Administration to deal with millions of beneficiaries and the additional premium offsets against their Social Security benefits. Those administrative costs would total about $4 billion through 2010 if sufficient funds to establish and operate the benefit were appropriated.

Effect of the Prescription Drug Benefit on Federal Purchasers of Drugs

Medicare enrollees who spent enough on prescription drugs to trigger the catastrophic coverage would no longer have to be conscious of the price of drugs. As a result, demand would grow and prices would increase for some drugs used heavily by Medicare enrollees—particularly drugs with no close substitutes. CBO estimates that, after 10 years, the average price of drugs consumed by Medicare beneficiaries would be 15 percent higher if the proposal were enacted.

Those higher prices would also affect spending for prescription drugs by other federal programs, such as Medicaid, the Federal Employees Health Benefits (FEHB) program, and programs of the Department of Defense (DoD), the Department of Veterans Affairs (VA), the Public Health Service (PHS), and the Coast Guard. CBO estimates that higher drug prices would add $2 billion over the 2001-2010 period to direct spending for Medicaid and for annuitants covered by the FEHB program. We estimate that the higher discretionary spending needed by federal agencies (for current workers covered by FEHB) as well as by DoD, VA, PHS, and the Coast Guard would total $0.5 billion over the 2001-2010 period.

Effect on Revenues

Higher drug prices would also lead to a loss of federal revenues from income and payroll taxes by raising the cost of employer-sponsored health insurance and correspondingly

reducing the amount of taxable compensation. CBO estimates that the decrease in revenues from income taxes and Medicare payroll taxes, which are on-budget, would amount to about $1 billion through 2010. The estimated decrease in Social Security payroll taxes, which are off-budget, would total $0.4 billion over through 2010.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	0	100	13,600	21,200	25,800	29,300	32,700	36,500	40,800	45,800
Changes in receipts	0	0	0	-10	-30	-60	-90	-120	-160	-200	-250

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The proposal contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act, although CBO estimates that state spending for Medicaid, on balance, would increase by about $1 billion over the 2001-2005 period.

State Medicaid programs initially would realize significant savings because the costs of some prescription drug benefits would be shifted to Medicare. In turn, Medicaid would pay premium and cost-sharing expenses for benefits provided under the new Part D program. The net effect of these two impacts would be a savings of about $2.4 billion over the 2001-2005 period. More than offsetting those savings, however, would be additional administrative expenses, higher drug costs, and, in particular, higher enrollment rates for low-income beneficiaries, resulting in about $3.4 billion in additional Medicaid costs to states over that period. On balance, the proposal would result in additional Medicaid spending approaching $1 billion from 2001 to 2005.

The proposal also would offer incentives to employers in order to encourage them to continue offering prescription drug benefits within their health insurance programs for

retirees. Depending on the degree to which their retirement programs met requirements of the proposal, state, local, and tribal governments could qualify for those incentives, thereby realizing savings in those programs.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The proposal contains no private-sector mandates as defined in the Unfunded Mandates Reform Act.

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